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Continuity of Care Obligations Under the No Surprises Act: A Practical Approach on Avoiding "Surprise" Liability and Patient Bills Under State and Federal Laws

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The interplay of continuity of care obligations under provider agreements and legislation at both the state and federal level, including the No Surprises Act, poses challenges to both payers and providers. This article offers an overview of the multitude of requirements and outlines a strategy for avoiding potential liability.

Provider agreements are commonplace in the health care industry. They create a network of hospitals and providers (among others) that provide care to members enrolled in a specific plan at a negotiated rate. Of course, providers may shift from being in-network to out-of-network for a variety of reasons, including upon the termination of a provider agreement.

When a provider agreement is terminated, an important issue arises related to patient care: what are the continuity of care obligations following termination? While providers and payers often negotiate and expressly outline these obligations in their provider agreements, Congress and state legislatures have determined that contractual protections may not be enough to guard against the potential disruption to patient care and surprise billing from the sudden termination of a provider agreement. Toward that end, the federal No Surprises Act, which took effect in 2022, requires that providers and payers ensure a patient continues to receive care and coverage for extended periods of time. A patchwork of state laws and regulations provide similar—and sometimes greater –protections. Providers and payers alike should have compliance with these private and public requirements on their radar.

Statutory Overview

Below is a brief overview of federal and state requirements on continuity of care for patients. While federal law has recently expanded on these requirements, many states have opted to go above and beyond in terms of coverage periods and disclosure requirements.

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Care Obligations Under Federal Law

No Surprises Act

On December 27, 2020, former President Trump signed into law the Consolidated Appropriations Act of 2021. Contained within that law are patient care requirements, commonly referred to as the No Surprises Act (NSA), which set forth federal continuity of care requirements for providers and payers. Among its goals, the NSA aims to guard against surprise billing for high-cost medical treatment following a termination by establishing thorough and robust continuity of care requirements.

The NSA's requirements apply to all health care providers and facilities and their treatment of "continuing care patients."[1] Such individuals fall within the following categories of patients who receive (or are about to receive) defined types of care, including those:

- Undergoing a course of treatment for a "serious and complex condition" from the provider or facility;
- Undergoing a course of institutional or inpatient care from the provider or facility;
- Scheduled to undergo nonelective surgery from the provider or facility, including receipt of post-operative care from such provider or facility with respect to such a surgery;
- Who are pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
- Who are or were determined to be terminally ill and are receiving treatment for such illness.[2]

Most patients fall under the first category of care—receiving care to treat a "serious and complex" condition. The NSA defines a "serious and complex" condition as requiring specialized medical treatment to avoid the reasonable possibility of death or permanent harm for acute illnesses, or is life threatening, degenerative, or disabling and requires specialized medical care over an extended period for chronic illnesses.[3]

If the continuing care patient's insurer terminates its relationship with that patient's provider, the insurer must comply with certain notice and coverage requirements.[4] Those requirements include: notifying the patient of the termination and their right to keep receiving care from the terminated provider, providing the patient with the opportunity to notify the plan or insurer of the need for transitional care, and allowing continuing care patients to elect to continue to have the same benefits provided.[5]

If the patient elects to continue receiving care from the terminated provider, the patient's benefits will remain in place for the earlier of 90 days or when the patient stops receiving care.[6] The provider must also accept payment from the insurer for up to 90 days and abide all agreed-on policies and procedures—including those under the parties' provider agreement—for that time period.[7]

Medicare Advantage Regulations

While the NSA does not apply to Medicare, Medicaid, or TRICARE beneficiaries,[8] insurance plans and issuers certified as Medicare Advantage Organizations (MAOs) by the Centers for Medicare & Medicaid Services (CMS) are subject to additional continuity of care requirements.[9] Under CMS regulations, MAOs offering coordinated care plans[10] must ensure continuity of care is provided for in their provider agreements by, among other things, adopting procedures, policies, and programs to make sure that patients maintain access to ongoing care.[11]

Care Obligations Under State Law

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The NSA is intended to supplement state continuity of care laws rather than replace them.[12] Thus, if a state has enacted a law that provides at least the same level of coverage and protection as the NSA, the state law will generally apply.[13]

A number of states impose continuity of care requirements that exceed the NSA, particularly regarding the coverage periods. For example, Nevada requires that "medically necessary" coverage be provided for 120 days or, in the case of a pregnancy, 45 days after the delivery or end of the pregnancy.[14] Similarly, Kentucky requires that, in the event of a provider termination, an insurer must provide services until the enrollee is discharged from an inpatient care facility, or the active course of treatment is completed, whichever period is greater.[15] Additionally, pregnant women must be provided services through the end of the post-partum period if the woman is in the fourth or later month of pregnancy at the time of termination.[16]

Other states also impose more stringent notice requirements for payers. For example, Colorado requires that a terminated provider produce a list of covered persons to the plan or issuer so that it may give covered persons written notice of the termination.[17] Virginia further requires that plans and issuers notify affected patients of a provider termination and proffer a list of other participating providers available to assume care and facilitate the patient's transition.[18]

Steps to Avoid "Surprise" Liability and Patient Bills Tied to Continuity of Care Requirements

The relatively recent enactment of the NSA may leave providers and payers unprepared for addressing their continuity of care requirements in the event of a termination. The varying obligations imposed at the state level only add to this confusion. This confusion poses serious consequences: a provider found in violation of the NSA may be subject to a civil monetary penalty of up to $10,000 per violation, while payers may be subject to a penalty of $100 per day for each individual affected by their non-compliance.[19]

The following provides best practices for how to approach a termination to ensure compliance with applicable legal requirements and make certain that patients receive the care they need.

Determine the Impacted Pool of Patients

In the event of a termination, providers and payers should immediately identify any patients who might be potentially affected. This determination will inform the parties' approach to disclosure of the termination, as well as their continuing care obligations.

Review the Provider Agreement

The parties should next review the provider agreement to determine whether it addresses post-termination care obligations.

Confirm Applicable State and Federal Laws

Once armed with an understanding of impacted members and contractual requirements, the parties should assess state and federal requirements, with the focus on the following:

- **Do the federal and state requirements for continuity of care exceed those outlined in the provider agreement?** The most stringent obligations should control.

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- **What portion of impacted plan members are either receiving medically necessary treatment or meet the definition of a continuing care patient under the NSA?** The parties should closely review statutory definitions when making these assessments.
- **What portion of impacted enrollees or beneficiaries have coverage under a state or federal health care program, such as Medicare or Medicaid?** While these individuals are not subject to the NSA (or to some state regulations, if preempted by federal law), they have additional protections that should be reviewed.

Err on the Side of Disclosure

The NSA and similar state laws are aimed at guarding against surprise billing for high-cost medical treatment. To that end, payers and providers should promptly notify patients of the termination and their rights and opportunities under the NSA and state laws (and the contract). While the termination of a business relationship can be a disruptive time, the parties still must comply with basic disclosure and election requirements for patients.

Conclusion

The continuity of care obligations imposed upon providers and payers should be closely followed in the lead up to and after a termination. Payers and providers alike should approach their obligations in a conscientious manner to ensure there are “no surprise” bills for patients receiving continuing care and “no surprise” liability for payers and providers.

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[1] *See* 29 U.S.C. § 1185g; 42 U.S.C. § 300gg-113.
[2] *See id.*
[3] *See id.*
[4] *See id.*
[5] *See id.*
[6] *See id.*

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[7] Centers for Medicare & Medicaid Services, *Frequently Asked Questions for Providers About the No Surprises Rules*, https://www.cms.gov/files/document/a274577-1b-training-2nsa-disclosure-continuity-care-directoriesfinal-508.pdf (Apr. 6, 2022).
[8] *See id.* (noting that individuals with coverage through federal health care programs do not qualify for protections under the NSA given that those programs already have "other protections against surprise medical bills").
[9] 42 C.F.R. § 422.112(b).
[10] A coordinated care plan is a plan that includes a network of providers under contract with the organization to deliver a benefit package approved by CMS. *See* 42 C.F.R. § 422.4.
[11] *See* 42 C.F.R. § 422.112(b) (explaining requirements for continuity of care).
[12] Centers for Medicare & Medicaid Services, *Questions and Answers on the No Surprises Act and State Laws*, https://www.cms.gov/files/document/nsa-state-laws-q-and-a.pdf (last visited Oct. 25, 2023).
[13] *Id.*
[14] NEV. REV. STAT. 695G.164.
[15] KY. REV. STAT. § 304.17A-527(1)(b).
[16] *See id.*
[17] *See* 3 COLO. CODE REGS. § 702-4-2-56-5.
[18] *See* 12 VA. ADMIN. CODE § 5-408-250.
[19] 42 U.S.C. § 300gg-134(b)(1); 42 U.S.C. § 300gg-22(b).

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